

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-025992

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

6864

STATE FILE NUMBER

FILED JUL 5 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN		Length of stay in 1b		c. CITY OR TOWN	
St. Louis		2 1/2 mo.		St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2815 Victor	
Lutheran Hospital		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
First Middle Last			Month Day Year		
Thomas G. Horsefield			6/29/63		
5. SEX	6. COLOR OR RACE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (last birthday)	IF UNDER 1 YEAR Months Days Hours Min.
Male	White		6/22/92	71	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country)	
Retired Pipe Fitter		American Car Co.		Catawissa, Mo.	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE	
Samuel Horsefield		Lillian Odell		Ann Horsefield	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			17. INFORMANT Address		
Yes WW #1			Ann Horsefield--2815 Victor St.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)					Cerebral Thrombosis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					one month
DUE TO (b)					Cerebral Arteriosclerosis
DUE TO (c)					33 2x
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year				
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE
21. I attended the deceased from 6/18/58 to 6/29/63 and last saw her alive on 6/29/63		Death occurred at 9:45 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title)		22b. ADDRESS		22c. DATE SIGNED	
Frederic Mortenson M.D.		3761 Shandel Sq		7/1/63	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Removal	7/2/63	National Cemetery		Jefferson Barracks, Mo.	
24. FUNERAL DIRECTOR ADDRESS		25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE	
WACKER-HELDERLE 3634 Gravois		JUL 1 1963		Road Smith. M.D.	

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

DATE AMENDED

INSTEAD OF

BY AFFIDAVIT OF

VS 300  
Rev. 4/59

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Delis J. Krupar*

Licensed Embalmer No. 3497

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.